Evidence for addition on cause of death shown on:

FILM No. G 128 OCT 27 1950

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

08882

Reg. Dist. No. 21

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A.A. |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mayo; LENGTH OF STAY (in this place) 8 mos. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MAYO |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS New DIXONA Rhode River Road | STREET ADDRESS (If rural give location) Dixona Road |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| THERESA | ANN | ADAMS | Sept | 18 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | Aug. 31, 1948 | 2 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Norfolk, Virginia | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Loraine S. Adams | June Kimball |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT |
|---|---|---|
| | | Mrs. June Adams |

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| **Immediate cause** | (a) Drowning | Sudden |
| **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Accidental | |
| | (c) | |

929.8
183

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Rhode River | (CITY OR TOWN) near Mayo | (COUNTY) A.A. | (STATE) Md |
|---|---|---|---|---|

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| Sept. 18, 1950 10 a.m. | | Wandered into river near home. (10-27-50-ams) |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John M. Gaffy M.D. | Deputy Medical Examiner | Annapolis Md | 9/18/50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 20, 50 | US Naval Cemetery | Annapolis, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Sept. 19, 1950 | Edward Collinson | B.E. Hopkins & Son | Annapolis, Md |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

Received
SEP 22 1950
Bureau of U. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

08883

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County Ann Arundel 6035 Ritchie Hghwy.

City or town Cedar Hill
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Week

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County

City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 904 W. Lexington St
(If rural, give LOCATION)

2.(a) If veteran, name war No ✓

**3. (a) FULL NAME** FLORINA BASS

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | C | WIDOWED |

6.(b) Name of husband or wife LAWENCE BASS

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1/8/1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 8 | 15 | ..... hrs. ..... min. |

9. Birthplace BALTIMORE? MD
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name ROBERT OTHO
13. Birthplace BALTO. MD

MOTHER
14. Maiden name MAGGIE WINN
15. Birthplace BALTO. MD

16. Informant PAULINE HINES (SISTER)

Address 6035 RITCHIE HIGHWAY

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 9/26/50 (month) (day) (year)

Cemetery or crematory BALTO. NAT'L. CEMETERY

Location BALTIMORE, MD.

18. Funeral director CHARLES G. COOPER

Address 512 N. CARROLLTON AVE-Balto. 23 Md.

19. 9/26 1950 (Date rec'd by registrar) [signature] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1950, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/21 1950, to 9/23 1950 and that I last saw her alive on 9/22 1950

| Immediate cause of death | DURATION |
|---|---|
| Coronary Insufficiency | 48 hrs. |
| Due to | |
| Due to 420.1 | |
| Other conditions | |
| 94a (Include pregnancy within 3 months of death) | |

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Preston Grant M. D. or other

Address 601 N. Carrollton. Balto. 17. Date signed 9/24/50.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
SEP 27 1950
BUREAU V. S

RECEIVED
SEP [illegible] 1950
[illegible] V. S

AGE: Drivers license, civil service and army papers filmed 10-25-50 G128 LL

08884

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CROWNSVILLE
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS KYLE RD. HERALD HARBOR

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE VIRGINIA COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ALEXANDRIA.
STREET ADDRESS (If rural, give location) 23 E. BRADDOCK RD

3. NAME OF DECEASED (Type or Print) (First) CHRISTOPHER (Middle) Columbus (Last) BENNETT

4. DATE OF DEATH (Month) SEPT. (Day) 30 (Year) 1950

5. SEX M
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Nov. 2, 1873
9. AGE last birthday 1878 77 71 yrs. If under 1 year Months 10 Days 28 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FINGERPRINT EXPERT
10b. KIND OF BUSINESS OR INDUSTRY U.S. GVT
11. BIRTHPLACE (State or foreign country) NEW JERSEY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WILLIAM BENNETT
14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO.
17. INFORMANT DR. OLLIE JOSEPHINE BENNETT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 420.1 | Immediate cause | (a) Coronary occlusion | sudden |
| 93d | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cardio-vascular hypertensive Disease | unknown |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Gaffy M.D. (Degree or title) Deputy Medical ADDRESS Examiner, Annapolis Md DATE SIGNED 9/30/50

23. ~~BURIAL, CREMATION~~ REMOVAL (Specify) Burial
DATE THEREOF 10-3-50
NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery
LOCATION (City, town, or county) (State) Alexandria Va.

DATE REC'D BY LOCAL REG. Sept. 30, 1950
REGISTRAR'S SIGNATURE R. M. Joyce
24. FUNERAL DIRECTOR Martin W. Hapong Co. ADDRESS 1300 N St NW Washington DC
License # 280

V7297

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 24 1950
BUREAU OF S

Evidence for change of #9 as shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

08885

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

FILM No. G 128 SEP 11 1950

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: Annapolis AA; STATE: MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
   LENGTH OF STAY (in this place):
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: AA General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: Hutton Place; COUNTY: AA Md.
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
   STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) EDWARD (Middle) (Last) BLAKE

4. DATE OF DEATH: (Month) Sept (Day) 2 (Year) 19 50

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 11-27-1916

9. AGE last birthday: ~~55~~ 33 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Davidsonville Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Sam Blake

14. MOTHER'S MAIDEN NAME: Alice Griffin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Chew

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Internal hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) due to Stab wound of abdomen

(c)

982X
168

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY Tavern
(CITY OR TOWN) Annapolis (COUNTY) Anne Arundel (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 2, 1950 1:15 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Stabbed during fight with William Gross

22. *I certify that I took charge of the remains described above, held an Autopsy* ☑, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, ~~Inspection~~ or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☐, *homicide* ☑, *undetermined* ☐.

SIGNATURE: Stanley K. Durlacher, M.D. (Degree or title) ADDRESS: 700 Fleet St., Baltimore Md. DATE SIGNED: Sept. 3, 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: Sept. 4, 1950
NAME OF CEMETERY OR CREMATORY: Brewer Hill
LOCATION (City, town, or county) (State): Annapolis, AA Md.

DATE REC'D BY LOCAL REG. 9-4-50
REGISTRAR'S SIGNATURE: R. W. Hebein M.R.

24. FUNERAL DIRECTOR: William Reese
ADDRESS: 108 Washington St Annapolis, Md.

866VV

08886

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 213 King Geo St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Katherine Buck Bootes
4. DATE OF DEATH (Month) (Day) (Year) 9 30 1950

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~ (Specify)
8. DATE OF BIRTH 12-19-1868
9. AGE last birthday 81 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) California
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joshua Shackford Buck
14. MOTHER'S MAIDEN NAME Anna A. Hooper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. —
17. INFORMANT AND ADDRESS Mrs Alan B. Sutherland Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocarditis Chr with Myocarditis | Several years |
| 422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Suffocating | Several |
| 93d | (c) Arthur Sclerosis generalized | Years |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension — Several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1950, to Sept. 30, 1950, that I last saw the deceased alive on Sept. 29, 1950, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George C Basil M D. ADDRESS Annapolis Md DATE SIGNED 10-1-50

23. BURIAL ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 10-3-50 NAME OF CEMETERY OR CREMATORY Naval Academy LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Oct. 2, 1950 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 3 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08887

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park | LENGTH OF STAY (in this place) 2½ months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedar Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS 3226 Pelham St. (Rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Bertha Ellen (Middle) Brown (Last)

4. DATE OF DEATH: (Month) 9/I/50 (Day) (Year) 19

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 3/I/78

9. AGE last birthday: 72 y yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Randolph, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathon Thompkins

14. MOTHER'S MAIDEN NAME: Lillia Sutliff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Cedar Crest N.Home Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General arteriosclerosis — Interval between onset and death: ?

450.0

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

97

(b) Senility — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/7/50, 19....., to 9/I/50, 19....., that I last saw the deceased alive on 8/30/50, 19....., and that death occurred at 9.20 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Gustave A Boeckeler M.D. Glen Burnie, Md. 9/I/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: Sept 4 50 | NAME OF CEMETERY OR CREMATORY: Susquehanna | LOCATION (City, town or county) (State): Susquehanna Pa

DATE REC'D BY LOCAL REG.: Sept 2. 1950 | REGISTRAR'S SIGNATURE: R.W.

24. FUNERAL DIRECTOR: Frank Pella Sons ADDRESS

M

08888

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Montgomery |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 1 mos. 22 days | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, Rockville |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital | STREET ADDRESS (If rural, give location): Route 1 ✓ |

| | | | | |
|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) George | (Middle) M. | (Last) Brown | 4. DATE OF DEATH (Month) 9/5/50 (Day) (Year) 19 |
| 5. SEX: male | 6. COLOR OR RACE: colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married | 8. DATE OF BIRTH: 4/17/77 | 9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none | 10b. KIND OF BUSINESS OR INDUSTRY: none | 11. BIRTHPLACE (State or foreign country): not known | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME: not known | 14. MOTHER'S MAIDEN NAME: not known | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS: Hosptal Records | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 442x Immediate cause | (a) Cardio-Renal Disease | known since 7/14/50 |
| 131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) Psychosis with Cardio-Renal Disease | known since 7/14/50 |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: none | 19b. MAJOR FINDINGS OF OPERATION: none | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify): none | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour): none m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? none |

22. I hereby certify that I attended the deceased from 7/14/50, 19....., to 9/5/50, 19....., that I last saw the deceased alive on 9/5/50, 19....., and that death occurred at 5:15 A. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Jacob Morgenstern | M.D. | Crownsville, Md. | 9/6/50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Removal | DATE THEREOF: 9/13/50 | NAME OF CEMETERY OR CREMATORY: University Med School | LOCATION (City, town, or county) (State): Balto City Md |
| DATE REC'D BY LOCAL REG.: [illegible] | REGISTRAR'S SIGNATURE: 9/14/50 | 24. FUNERAL DIRECTOR: Frances A Hensley | ADDRESS: 578 N Biddle St |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
SEP 19 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08889

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edenton | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edenton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) John (Middle) W. (Last) Chidley

4. DATE OF DEATH: (Month) Sept. (Day) 8 (Year) 1950

5. SEX: male | 6. COLOR OR RACE: Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married | 8. DATE OF BIRTH: Feb. 18, 1881 | 9. AGE last birthday: 69 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baltiman P.R.R. | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): A. A. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown | 14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS: Lucinda Coutee

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: 15 Min

420.1 Antecedent cause(s)

932 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vascular disease — 18 Months.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to Sept 8, 1950, that I last saw the deceased alive on Sept 7, 1950, and that death occurred at 9:15A m., from the causes and on the date stated above.

SIGNATURE: Edward J Merritt (Degree or title) M.D. | ADDRESS: Cambrills Md | DATE SIGNED: 9-8-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: Sept. 11/50 | NAME OF CEMETERY OR CREMATORY: Works Cem. | LOCATION (City, town, or county) (State): Edenton, N.C. Ind.

DATE REC'D BY LOCAL REG.: Sept. 11, 1950 | REGISTRAR'S SIGNATURE: M. E. Byrd

24. FUNERAL DIRECTOR: J. B. Johnson | ADDRESS

6449

RECEIVED
SEP 26 1950
BUREAU V. S

08890

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place) 3 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Oakwood Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS Same (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Frank (Middle) (Last) CSISINKO
4. DATE OF DEATH (Month) Sept. (Day) 5 (Year) 1950

5. SEX Male.
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) married
8. DATE OF BIRTH 9/10/1907
9. AGE last birthday 42 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer.
10b. KIND OF BUSINESS OR INDUSTRY Dellabeski
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew CSISINSKO
14. MOTHER'S MAIDEN NAME Catherine Jacobs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)
16. SOCIAL SECURITY NO. 217-05-9976
17. INFORMANT AND ADDRESS Mrs. Margaret Csisinsko (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH 6 months?

002x

Antecedent cause(s)

13b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 8/6, 1950, to 9/5, 1950, that I last saw the deceased alive on 9/4/, 1950, and that death occurred at 8:05 P.m., from the causes and on the date stated above.

SIGNATURE Gustave H. Pauber MD. (Degree or title) ADDRESS Glen Burnie 6, Md. DATE SIGNED 9/5/50.

23. BURIAL, CREMATION REMOVAL (Specify) burial
DATE 9/9/50
NAME OF CEMETERY OR CREMATORY Moreland Park
LOCATION (City, town, or county) (State) Parkville, Md.

DATE REC'D BY LOCAL REG. 9/7/50
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul St. ADDRESS

JT

346V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08891

# CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A A Co. STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY AA Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) FRANIS (Middle) P. (Last) CURRAN

4. DATE OF DEATH: (Month) Sept (Day) 4 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed

8. DATE OF BIRTH: Dec 25, 1869

9. AGE last birthday: 80 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MATHEW CURRAN

14. MOTHER'S MAIDEN NAME: Bridget LACEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) –
(If year, give war or dates of service) –

16. SOCIAL SECURITY NO.

17. INFORMANT: MISS LAURETTA CURRAN, PASADENA, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: Immediate

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Coronary Sclerosis — 10 years

(c) Hypertensive Cardio Vascular Renal — 5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/28, 1946, to 9/4, 1950, that I last saw the deceased alive on 8/24, 1950, and that death occurred at 5:00 P m., from the causes and on the date stated above.

SIGNATURE: J. Brady Smith (Degree or title) M.D. ADDRESS: Riviera Beach, Md. DATE SIGNED: 9/6/50

23. BURIAL, CREMATION / REMOVAL (Specify): BURIAL DATE: Sept 7, 1950 NAME OF CEMETERY OR CREMATORY: Holy Cross LOCATION (City, town, or county): Annapolis Rd. (State): Md.

DATE REC'D BY LOCAL REG.: Sept. 6, 1950 REGISTRAR'S SIGNATURE: G W Hedrich

24. FUNERAL DIRECTOR: John F. Denny Inc. ADDRESS: 715 Light St.

JCL

XVX99

VS. A15

Evidence for addition in 8 shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08892

FILM No. G 1 28 SEP 26 1950

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Balt.City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural, give location): not known

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): John Doe #7

4. DATE OF DEATH (Month) (Day) (Year): 9/2/50 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): not known

8. DATE OF BIRTH: approx. 46 not known

9. AGE last birthday: 46 not known yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known

10b. KIND OF BUSINESS OR INDUSTRY: not known

11. BIRTHPLACE (State or foreign country): not known

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ~~xxxxxxxxxxxxxxxxxx~~

16. SOCIAL SECURITY NO. ~~xxxx~~

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Paresis — INTERVAL BETWEEN ONSET AND DEATH: known since 4/29/50

025X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

30b

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): none

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): none

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 4/29/49, 19....., to 9/2/50, 19....., that I last saw the deceased alive on 9/2/50, 19....., and that death occurred at 7:18P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Morgenstern M.D. — ADDRESS: Crownsville, Md. — DATE SIGNED: 9/5/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 9/7/50 — NAME OF CEMETERY OR CREMATORY: Crownsville — LOCATION (City, town, or county) (State): Crownsville, Md.

DATE REC'D BY LOCAL REG.: Sept. 7, 1950 — REGISTRAR'S SIGNATURE: M. E. Jacob — 24. FUNERAL DIRECTOR: Dr. Jacob Morgenstern — ADDRESS: Crownsville

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 18 1950
BUREAU V. S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08893

# CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Ferndale - ANNE ARUNDEL; MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale
   LENGTH OF STAY (in this place) All his life
   HOSPITAL OR INSTITUTION OR STREET ADDRESS None

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Ferndale. COUNTY A.A. Co.
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale.
   STREET ADDRESS (If rural, give location) 212 Hoelen Ferry Rd. - Ferndale. Star Route R.D.

3. NAME OF DECEASED (Type or Print): (First) Amanda (Middle) Virginia (Last) Downs

4. DATE OF DEATH: (Month) Sept. (Day) 19 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed.

8. DATE OF BIRTH: June 7, 1875

9. AGE last birthday: 75 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY Housework.

11. BIRTHPLACE (State or foreign country): A.A. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hodson D. K - Conner -

14. MOTHER'S MAIDEN NAME: Elizabeth Pusey.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Downs (Son) 203 Wickelow Ave

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Valvular Disease of the Heart — Interval between onset and death: 15 years.

444x Antecedent cause(s)

92d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) High Blood Pressure — 15 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 1940, to Sept 19....., 1950, that I last saw the deceased alive on Sept 19....., 1950, and that death occurred at 11:40 P.m., from the causes and on the date stated above.

SIGNATURE James S. Bellingsley (Degree or title) M.D ADDRESS 108 Central Ave. Glen Burnie Md DATE SIGNED Sept 20, 1950.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial. DATE: Sept. 22, 1950 NAME OF CEMETERY OR CREMATORY: Meadow Ridge Memorial Park. LOCATION (City, town, or county) (State): Howard Co. Md.

DATE REC'D BY LOCAL REG. 9/21/50 REGISTRAR'S SIGNATURE A.W. Hedrick

24. FUNERAL DIRECTOR: Wm. J. Fisher & Son. ADDRESS: Balt. Md.

ST

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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T

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08894

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rear of #303 - 6th. Ave. N. E.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural, give location) Rear of #303 - 6th Ave. N. E.

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) H. (Last) Dunn

4. DATE OF DEATH (Month) Sept. (Day) 12 (Year) 1950

5. SEX Female

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow

8. DATE OF BIRTH May 22, 1867

9. AGE last birthday 83 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY own Home

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Herman Wockenfuss

14. MOTHER'S MAIDEN NAME Justina Chevofski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT AND ADDRESS Miss Louise Dunn - Rear of #303 - 6th. Ave. N.E. Glen Burnie, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Uterus

174X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

48b (c)

INTERVAL BETWEEN ONSET AND DEATH: 6 mos

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 15 - 1950, to Sept 12th 1950, that I last saw the deceased alive on Sept 10 - 1950, and that death occurred at 6 30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Joseph Lipsey M.D. ADDRESS Odenton Md DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Sept. 15, 1950 NAME OF CEMETERY OR CREMATORY Cedar Hill LOCATION (City, town, or county) Brooklyn, R.F.D. (State) Md.

DATE REC'D BY LOCAL REG. 9-15-50 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR R. V. Singleton ADDRESS Glen Burnie

RECEIVED
SEP 19 1960
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08895

# CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Drury, Md.
LENGTH OF STAY (In this place) 44 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Drury Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Drury, Md
STREET ADDRESS (If rural, give location) Drury (Lothian P.O.)

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Eldridge (Last) Franklin

4. DATE OF DEATH: (Month) Sept (Day) 27 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: Jan 31, 1906

9. AGE last birthday: 44 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Road work (State)

11. BIRTHPLACE (State or foreign country): Drury Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Franklin

14. MOTHER'S MAIDEN NAME: Pauline Owens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-12-4397

17. INFORMANT (Wife) Mary Elizabeth Franklin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Rectum with Metastasis

154 X
46 d

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Dec 15, 1949

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Rectum with Metastasis

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 19 49, to Sept, 19 50, that I last saw the deceased alive on Sept 27, 19 50, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Clifton R. Hines, M.D. School St. Upper Marlboro, Md. 9/27/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Oct. 1, 1950

NAME OF CEMETERY OR CREMATORY: Moses

LOCATION (City, town, or county) (State): Drury, Md

DATE REC'D BY LOCAL REG. Oct. 1. 50

REGISTRAR'S SIGNATURE: J. B. Dent

21. FUNERAL DIRECTOR: T. A. Hardesty & Son ADDRESS

9598

VS. A15

RECEIVED
OCT 3 1950
BUREAU T. S.

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08896

## CERTIFICATE OF DEATH

Reg. Dist. No. 239

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN rural Laurel
LENGTH OF STAY (in this place) 3 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Prince George's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Seabrook
STREET ADDRESS (If rural, give location) rural. ✓

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Day (Last) Fraser

4. DATE OF DEATH: (Month) 9 (Day) 9 (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Jan 11 1894

9. AGE last birthday: 56 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): hospital attendant

10b. KIND OF BUSINESS OR INDUSTRY: hosp + farm

11. BIRTHPLACE (State or foreign country): Manassas, Virginia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: William Longwell

14. MOTHER'S MAIDEN NAME: Elizabeth Sinclair

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: William Asa Carr (son) Seabrook, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral hemorrhage | 3 hours |
| 331 Antecedent cause(s) 83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension | 40 years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-9-50, 19..., to 9-9-50, 19..., that I last saw the deceased alive on 9-9-50, 19..., and that death occurred at 9 20 A.M., from the causes and on the date stated above.

SIGNATURE: J. A. Alston M.D. (Degree or title) ADDRESS: District Training School Laurel Md. DATE SIGNED: 9-9-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 9/12/50
NAME OF CEMETERY OR CREMATORY: Ft Lincoln
LOCATION (City, town, or county) (State): Colmar Manor Md

DATE REC'D BY LOCAL REG. 9-9-50
REGISTRAR'S SIGNATURE: Amanda Downey M. Busheare

24. FUNERAL DIRECTOR: F. Eusche Sons ADDRESS: Hyattsville Md

79092

RECEIVED
SEP 13 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08897

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE; LENGTH OF STAY (in this place) 7 YRS.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 403 CRAIN HWY. N.E.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE; STREET ADDRESS (If rural, give location) 403 CRAIN HWY. N.E.

3. NAME OF DECEASED (Type or Print): (First) EDEN (Middle) E. (Last) GARDNER.

4. DATE OF DEATH: (Month) SEPT. (Day) 14. (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: OCT. 7, 1898

9. AGE last birthday: 51 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER

10b. KIND OF BUSINESS OR INDUSTRY: U.S. COAST GUARD

11. BIRTHPLACE (State or foreign country): SEVERN MD

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: SOLAN GARDNER

14. MOTHER'S MAIDEN NAME: LEANA GARDNER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: NONE

17. INFORMANT AND ADDRESS: ELLWOOD GARDNER 3606 SOUTHERN AVE. BALTIMORE 14, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Embolism

465X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

111a (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/24, 1950, to 9-11, 1950, that I last saw the deceased alive on 9-11, 1950, and that death occurred at 8:15 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Charles R. MacDonald M.D. Glen Burnie Md 9-14-50

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL | DATE THEREOF: SEPT. 16 1950 | NAME OF CEMETERY OR CREMATORY: GLEN HAVEN | LOCATION (City, town, or county) (State): GLEN BURNIE, MD.

DATE REC'D BY LOCAL REG.: 9/16/50 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS: Thomas W. Dengler Glen Burnie, Md

34098

34098

RECEIVED
SEP 19 1950
U.S. BUREAU

08898

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lake Shore
LENGTH OF STAY (In this place) 2 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5 Park Drive

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LAKE SHORE, PASADENA, P.O.
STREET ADDRESS (If rural give location) 5 PARK DRIVE

3. NAME OF DECEASED (Type or Print) (First) CHARLES (Middle) W. H. (Last) GLANZER
4. DATE OF DEATH (Month) Sept. (Day) 11 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wid.
8. DATE OF BIRTH Nov. 8, 1883
9. AGE last birthday 66 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter & Coppersmith
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY U.S.A

13. FATHER'S NAME unknown.
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Charles W. O. Glanzer Box 494 Route 1 Severna Park

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 420.1 | Immediate cause | (a) Coronary Occlusion | sudden |
| 94a | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary Sclerosis | unknown |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 9/11/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9/14/50
NAME OF CEMETERY OR CREMATORY Meadowridge
LOCATION (City, town, or county) (State) Howard Co., Md.

DATE REC'D BY LOCAL REG. 9/12/50
REGISTRAR'S SIGNATURE H. W. Hedrick Jrs
24. FUNERAL DIRECTOR Wm. J. Tickner & Sons ADDRESS Balto Md

34847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

18899

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CROWNSVILLE — LENGTH OF STAY (in this place) 1 YEAR 2 MONTHS
HOSPITAL OR INSTITUTION OR STREET ADDRESS CROWNSVILLE STATE HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY BALT. CITY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE
STREET ADDRESS (If rural, give location) NOT KNOWN ✓

3. NAME OF DECEASED (Type or Print): (First) HATTIE (Middle) (Last) GREEN

4. DATE OF DEATH: (Month) 9 (Day) 6 (Year) 50 19

5. SEX: FEMALE

6. COLOR OR RACE: COLORED

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: 2/5/12

9. AGE last birthday: 38 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): NOT KNOWN

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: NOT KNOWN

14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: HOSPITAL RECORDS

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

025 Immediate cause (a) GENERAL PARESIS — INTERVAL BETWEEN ONSET AND DEATH: KNOWN SINCE 7/2/49

30b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION: NONE

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NONE

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: NONE — (CITY OR TOWN): NONE — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): NONE m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? NONE

22. I hereby certify that I attended the deceased from 7/2/49, 19..., to 9/6/50, 19..., that I last saw the deceased alive on 9/6/50, 19..., and that death occurred at 12:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jacob Morgenstern M.D. CROWNSVILLE MD. 9/6/50

23. BURIAL, CREMATION REMOVAL (Specify): Buried — DATE THEREOF: 9/16/50 — NAME OF CEMETERY OR CREMATORY: Crownsville Cemetery — LOCATION (City, or county) (State): Crownsville, Md.

DATE REC'D BY LOCAL REG.: Sept. 17, 1950 — REGISTRAR'S SIGNATURE: M.E. Joyce

24. FUNERAL DIRECTOR — ADDRESS: Dr. Jacob Morgenstern

XV×49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 26 1950
BUREAU OF S

08900

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garland
LENGTH OF STAY (in this place) Summer Home
HOSPITAL OR INSTITUTION OR STREET ADDRESS III Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 118 S.Broadway

3. NAME OF DECEASED (Type or Print) (First) Thaddeus (Middle) Grzegorzak (Last) Grzegorzak

4. DATE OF DEATH (Month) Sept. (Day) 8 (Year) 1950 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 10/31/90
9. AGE last birthday 59 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker
10b. KIND OF BUSINESS OR INDUSTRY Self-Employed
11. BIRTHPLACE (State or foreign country) Poland, Europe
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Leon Grzegorzak
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Theresa Grzegorzak 118 S.Broadway

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — Sudden

420.1

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

9 Ha

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. --

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Barber M.D. (Degree or title) Assistant Deputy Med. Examiner
ADDRESS Glen Burnie, Md.
DATE SIGNED 9/8/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept 11, 1950
NAME OF CEMETERY OR CREMATORY Holy Cross (Brooklyn)
LOCATION (City, town, or county) (State) Anne Arundel County

DATE REC'D BY LOCAL REG. Sept 9/1950
REGISTRAR'S SIGNATURE R.W.
24. FUNERAL DIRECTOR George A. Weber
ADDRESS 705 S. Ann st

15689

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08901

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General Hospt

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harwood
STREET ADDRESS (If rural give location) R. F. D.

3. NAME OF DECEASED (Type or Print): (First) JERE. (Middle) MICHAEL (Last) GUISE

4. DATE OF DEATH: (Month) 9 (Day) 17 (Year) 1950

5. SEX: M. | 6. COLOR OR RACE: White | 7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) | 8. DATE OF BIRTH: 10-16-1949 | 9. AGE last birthday: 11 mths. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child | 10b. KIND OF BUSINESS OR INDUSTRY: — | 11. BIRTHPLACE (State or foreign country): Honolulu- | 12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Stanley A. Guise | 14. MOTHER'S MAIDEN NAME: Dorothy Russell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. — | 17. INFORMANT: Roger W. Guise York Springs Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

917.0 Immediate cause (a) End°-Burn- 50 % Body.

181 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) Thermal. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home. | (CITY OR TOWN) Edgewater. | (COUNTY) A.A.Co. | (STATE) Md.

TIME OF INJURY (Month) 9 (Day) 15 (Year) 50 (Hour) 5:30 p.m. | INJURY OCCURRED While at Work ☐ Not While At work ☑ | HOW DID INJURY OCCUR? Spilled hot COFFEE (Child pulled cord (attached to percolator))

22. I hereby certify that I attended the deceased from 9.15.50., 19....., to 9.17.50, 19....., that I last saw the deceased alive on 9.17.50, 19....., and that death occurred at 9:17 a.m., from the causes and on the date stated above.

SIGNATURE: E. Lee Lacht. | (Degree or title) MD. | ADDRESS Crapo. | DATE SIGNED 9-17-50.

23. BURIAL, CREMATION, REMOVAL (Specify) Removal | DATE THEREOF 9-20-1950 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) York Springs | (State) Pa.

DATE REC'D BY LOCAL REG. Sept. 17, 1950 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR R. L. Patterson | ADDRESS York Springs Pa.

9V 0169 190 M 40

VS. A15

RECEIVED
SEP 20 1950
BUREAU OF S

08902

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (In this place) 10 years 11 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crisfield
STREET ADDRESS (If rural, give location) Box 242

3. NAME OF DECEASED (Type or Print) (First) Frank (Middle) (Last) Hale
4. DATE OF DEATH (Month) (Day) (Year) 9/11/50 19
5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH 6/18/95
9. AGE last birthday 55 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Connecticut
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Henry Hale
14. MOTHER'S MAIDEN NAME Emma Mikans
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ********
16. SOCIAL SECURITY No. ********
17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

331X

83a

INTERVAL BETWEEN ONSET AND DEATH: known for 42 hours

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mental Defiency without Psychosis known since 10/14/39

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) none
TIME OF INJURY (Month) (Day) (Year) (Hour) none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 10/14/39, 19....., to 9/11/50, 19....., that I last saw the deceased alive on 9/11/50, 19....., and that death occurred at 1:25 P. m., from the causes and on the date stated above.

SIGNATURE Jacob Margenstern M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 9/11/50

23. BURIAL, CREMATION REMOVAL (Specify) Buried
DATE THEREOF 9/16/50
NAME OF CEMETERY OR CREMATORY Crownsville Cemetery
LOCATION (City, town, or county) (State) Crownsville, Md.

DATE REC'D BY LOCAL REG. Sept. 17, 1950
REGISTRAR'S SIGNATURE M. E. Joyce
24. FUNERAL DIRECTOR Dr. Jacob Margenstern ADDRESS

XUX49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 26 1960
BUREAU Y. S

08903

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie | LENGTH OF STAY (In this place) 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Furnace Branch Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Baltimore~~
STREET ADDRESS (If rural give location) Furnace Branch Rd. A.A.Co. Md.

3. NAME OF DECEASED (Type or Print): (First) (Middle) (Last) Florence Evelynn Hartenstein

4. DATE OF DEATH (Month) (Day) (Year): Sept. 28 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 10/20/07

9. AGE last birthday: 42 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Louis S. Hartenstein

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Occlusion — Interval Between Onset and Death: Sudden

94 a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Pambrun (Degree or title) ADDRESS Assistant Medical Exam. Glen Burnie, Md. DATE SIGNED 9/28/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Oct 2, 1950 | NAME OF CEMETERY OR CREMATORY Holy Cross | LOCATION (City, town, or county) (State) A. A. Co. Md.

DATE REC'D BY LOCAL REG. 9-30-50 | REGISTRAR'S SIGNATURE RW | 24. FUNERAL DIRECTOR ADDRESS Flynn & Fleming 1426 Light St.

M

08904

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Anne Arundel Co MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 50 Yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 4 Pleasant Court | STREET ADDRESS (If rural give location) 4 Pleasant Court |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Elizabeth | (Middle) ------ | (Last) Hawkins | 4. DATE OF DEATH | (Month) (Day) (Year) 9/9/1950 19 |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 10/10/1887 | 9. AGE last birthday 62 yrs. | If under 1 year Months Days; If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | 10b. KIND OF BUSINESS OR INDUSTRY Employed None | | 11. BIRTHPLACE (State or foreign country) Davidsonville, Maryland | 12. CITIZEN OF WHAT COUNTRY? ---------- | |
| 13. FATHER'S NAME John Wesley Evans | | | 14. MOTHER'S MAIDEN NAME Annie Johnson | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N (If yes, give war or dates of service) ---- | | 16. SOCIAL SECURITY No. None | 17. INFORMANT Pearl Hawkins | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X Immediate cause (a) Cerebro-vascular accident

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 9-2, 1950, to 9-9-50, 19....., that I last saw the deceased alive on 9-8-50, 19....., and that death occurred at 10 p.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| G. T. Allen | M D | 10 Carroll St | 9-12-50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 9/13/1950 | NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery | LOCATION (City, town, or county) (State) West St. -Annapolis, Md. |
| DATE REC'D BY LOCAL REG. Sept. 13, 1950 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR Mrs. Charles E. Hicks & Son | ADDRESS 45 Northwest St. |

72099

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 14 1950
BUREAU V. S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

08905

Reg. Dist. No. 28

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 2 yrs. 5 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1804 McCulloh Street

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Rosetta | | James | 9 | 20 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | If under 24 hrs.: Days | Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Negro | Separated | 10/19/81 | 68 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | - - - | Virginia | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Thomas | Jenny Billop |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | - - - - - - - - - | Hospital Records |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 422.1 Immediate cause | (a) Cardio-vascular disease | Known to us |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 48b | (b) Cardio-vascular disease | Known since adm. adm. 4/16/48 |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cancer of uterus?

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| - - - - - - - | - - - - - - - - - - - - - - - - - - - - | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| - - - - | - - - - | - - - - - - - - - - - - - - - - - - - - | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| - - - - - - - - m. | - - - - | - - - - - - - - - - - - - - - - - - - - |

22. I hereby certify that I attended the deceased from 4/16, 1948, to 9/20/, 1950, that I last saw the deceased alive on 9/20/, 1950, and that death occurred at 9:15p. m., from the causes and on the date stated above.

SIGNATURE: L Beaudit (Degree or title) M. D. ADDRESS: Crownsville, Maryland DATE SIGNED: 9/21/50

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Sept 24, 1950 | M.H. Cullum | Baltimore, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-22-50 | M E Jones | Geo. A. Kelson | 1303 Eutaw |

XV149

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 27 1950
BUREAU V. S

M

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

08906

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Arundle Co

City or town: Severn (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Severn, Md

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County:

City or town: Severn (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Charles O. Johnson

**3. (b) Social Security Number:**

4. Sex: Male

5. Color or race: Col

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Beatrice L. Johnson

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 8-20-1889

**8. AGE:** Years: 61 | Months: | Days: | If less than one day ... hrs. ... min.

9. Birthplace: Arundle Co., Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm Owner

FATHER

12. Name: Charles H. Johnson

13. Birthplace: Md

MOTHER

14. Maiden name: Matilda Parker

15. Birthplace: Md.

16. Informant: Beatrice L. Johnson

Address: Severn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10. 1950 (month) (day) (year)

Cemetery or crematory: Ft Rest Cemetery

Location: Anne Arundle County Maryland

18. Funeral director: Joseph A. Lucy

Address: 661 West Barre St Baltimore 30 Md

19. 9-8-50 19 (Date rec'd by registrar) L Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 7 1950, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 1949 to Sept 6 1950 and that I last saw him alive on Sept 6 1950

Immediate cause of death: Carcinoma of liver

Due to:

Due to:

Other conditions: 156.1 (Include pregnancy within 3 months of death)

46f

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Thos J Woolridge M. D. or other

Address: Elkridge 27 Md R4 Box 212 Date signed: 9-8-50

08907

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
LENGTH OF STAY (in this place) 60 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ridge Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover
STREET ADDRESS (If rural, give location) Ridge Road

3. NAME OF DECEASED (Type or Print) (First) SAMUEL (Middle) DARBY (Last) JOHNSON
4. DATE OF DEATH (Month) Sept. (Day) 16 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Apr. 22, 1888
9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WILLIAM G. JOHNSON
14. MOTHER'S MAIDEN NAME ANNIE JOHNSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY No. 218-14-0474
17. INFORMANT Mrs. Isabel Harmon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary Occlusion | sudden |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary Sclerosis | unknown |
| | (c) | |

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, occident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 9/16/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Sept 18-1950
NAME OF CEMETERY OR CREMATORY melville cem
LOCATION (City, town, or county) Elkridge (State) md

DATE REC'D BY LOCAL REG. 9/18/50
REGISTRAR'S SIGNATURE A. W. Hearsey
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co ADDRESS

JT

308V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

08908

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital D.O.A.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural give location) 102 - 4th Ave. S.E

3. NAME OF DECEASED (Type or Print): (First) STEVE (Middle) WILLIAM K. (Last) KALANDROS
4. DATE OF DEATH: (Month) Sept. (Day) 12 (Year) 1950

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | MARRIED | 8-24-1901 | 49 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| OWNER | RESTAURANT | LIPSO GREECE | U. S. |

13. FATHER'S NAME: WILLIAM KALANDROS
14. MOTHER'S MAIDEN NAME: ATHENA BAMOULA S.E.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | UNKNOWN | MRS. VIRGINIA KALANDROS 102 FOURTH AVE GLEN BURNIE, MD |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause (a) | Crushed left Chest & Internal Hemorrhage | Sudden |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) | Automobile Collision | |
| (c) | | |

8/16.5/70c

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: multiple injuries

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office building) OF INJURY Ritchie Highway | (CITY OR TOWN) near Annapolis | (COUNTY) A.A. | (STATE) Md |
|---|---|---|---|---|

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☑ | HOW DID INJURY OCCUR? |
|---|---|---|
| 9/12/50 10p.m. about | | automobile Collision - 2 motor vehicles |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John M. Raffety | M.D. Deputy Medical Examiner | Annapolis Md | 9/12/50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | SEPT. 16 1950 | GLEN HAVEN | GLEN BURNIE MD |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | [illegible] | Thomas W. Singleton | Glen Burnie, Md. |

15671

M

08909

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md ~~COUNTY~~ Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1307 Central Ave

3. NAME OF DECEASED (Type or Print) (First) Truman (Middle) K (Last) Knight
4. DATE OF DEATH (Month) 9 (Day) 10 (Year) 1950

5. SEX male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) ?
8. DATE OF BIRTH 1922 ?
9. AGE last birthday 28 ? yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown
10b. KIND OF BUSINESS OR INDUSTRY Steel Plant
11. BIRTHPLACE (State or foreign country) Unteco Va
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Tuberculosis of the lung

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH known to us since 9-3-50

002X

13b

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 3rd, 1950, to Septemb 10th 1950, that I last saw the deceased alive on Sept. 9th, 1950, and that death occurred at 6:15 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jacob Morgenstern M.D.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9-12-50
NAME OF CEMETERY OR CREMATORY Mt Calery
LOCATION (City, town, or county) (State) Brooklyn Md

DATE REC'D BY LOCAL REG. 9-10-50
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR Elroy O Wilson ADDRESS 1000 Brantley Ave

988 29

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

08310

Reg. Dist. No. 28

M — The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) two mos. 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 202 N. Fremont Avenue ✓

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | Leroy | Harold | Lawrence | | 9/14/50 | | 19 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | colored | married | 11/25/06 | 43 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Janitor | none | Baltimore, Maryland | |

13. FATHER'S NAME: Leory Lawrence
14. MOTHER'S MAIDEN NAME: Laura Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ********** 16. SOCIAL SECURITY NO. ********
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Respiratory failure | 2 hours |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) following Electro-shock treatment | |
| | (c) Schizophrenia- Paranoid Type | Known to us since adm. 6/29/50 |

955.1
195.8

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office building, hospital) OF INJURY Hospital
(CITY OR TOWN) Crownsville (COUNTY) Anne Arundel (STATE) Maryland

TIME OF INJURY (Month) 9 (Day) 14 (Year) 50 (Hour) 8:00a m
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Following Electro-shock treatment

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John M. Caffey M.D. | Deputy Medical Examiner | Annapolis Md | 9/15/50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| 9/18/50 | Burial | Arbutus Mem. Park | Balto. Co., Md. | |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9/18/50 | A. W. Hedrick | Williams A. Jackson | 916 Penna. Ave |

JT ✓ 24099

VS. A15A

Evidence for change of age shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08911

# CERTIFICATE OF DEATH

Reg. Dist. No.

FILM No. G 128 OCT 19 1950

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Anne Arnudel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balt.City |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 3 mos. 25 days | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital | STREET ADDRESS (If rural, give location): 428 Robert Street |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Sallie | (Middle) Christmas | (Last) Lee | 4. DATE OF DEATH | (Month) 9/27/50 (Day) (Year) 19 |
| 5. SEX: female | 6. COLOR OR RACE: colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow | 8. DATE OF BIRTH: 12/14/92 | 9. AGE last birthday: 57 ~~68~~ yrs. | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none | 10b. KIND OF BUSINESS OR INDUSTRY: none | 11. BIRTHPLACE (State or foreign country): Warrenton, N. C. | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME: Christopher Christmas | 14. MOTHER'S MAIDEN NAME: Eliza Ruff | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, ~~give war or dates of~~ service) | 16. SOCIAL SECURITY No.: ~~XXXXXX~~ | 17. INFORMANT AND ADDRESS: Hospital Records | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Generalized Arteriosclerosis | known since 6/2/50 |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) Sehile Psychosis | " " |

450.0

97

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: none | 19b. MAJOR FINDINGS OF OPERATION: none | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify): none | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): none | |
| TIME OF INJURY (Month) (Day) (Year) (Hour): none m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? none |

22. I hereby certify that I attended the deceased from 6/2/50, 19....., to 9/27/50, 19....., that I last saw the deceased alive on 9/27/50, 19....., and that death occurred at 5:45 P. m., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern M.D. (Degree or title) ADDRESS: Crownsville, Maryland DATE SIGNED: 9/28/50

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Sept. 30, 1950 | NAME OF CEMETERY OR CREMATORY: Greenwood | LOCATION (City, town, or county) (State): Warrenton, N. C. |
| DATE REC'D BY LOCAL REG.: Sept. 30th 1950 | REGISTRAR'S SIGNATURE: R.W. | 24. FUNERAL DIRECTOR: Holland Funeral Firm 1631 Druid Hill Ave. | ADDRESS |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08912

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place) 13 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS 62 SOUTHGATE AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
STREET ADDRESS (If rural, give location) 62 SOUTHGATE AVE

3. NAME OF DECEASED (Type or Print) (First) RACHEL (Middle) (Last) LOTT

4. DATE OF DEATH (Month) SEPT (Day) 28 (Year) 1950

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED
8. DATE OF BIRTH SEPT. 2, 1860
9. AGE last birthday 90 yrs. If under 1 year Months 0 Days 2 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY OWN
11. BIRTHPLACE (State or foreign country) AULUXT, LATVIA
12. CITIZEN OF WHAT COUNTRY? USA (YES)

13. FATHER'S NAME JACOB WERNZ
14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. NONE
17. INFORMANT AND ADDRESS MRS FANNIE SCHENKER DAUGHTER 62 SOUTHGATE AVE ANNAPOLIS, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cardiac decompensation | 2 days |
| 442x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 131a | (b) Advanced Cardio-Vasc. - Renal Disease | yrs. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Severe secondary anaemia - Dietary

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1947, to Sept. 28, 1950, that I last saw the deceased alive on Sept. 28, 1950, and that death occurred at 330P m., from the causes and on the date stated above.

SIGNATURE Maurice Klawans, MD (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 9/28/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF 9-29-50
NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL
LOCATION (City, town, or county) (State) 3 MILE OAK, NR ANNAPOLIS, MD.

DATE REC'D BY LOCAL REG. 9/29/50
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. HOPPINE + SON ADDRESS 170-172 WEST ST. ANNAPOLIS, MD.

RECEIVED
SEP 30 1950
BUREAU V. S

(M)

08913

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY a a. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 305 Chesapeake Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY a a
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 305 Chesapeake

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) Ella (Last) Lowman

4. DATE OF DEATH (Month) Sept (Day) 9th (Year) 1950

5. SEX F

6. COLOR OR RACE W.

7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH 11-23-1867

9. AGE last birthday 82 yrs. If under 1 year: Months | Days. If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Frederick Md

12. CITIZEN OF WHAT COUNTRY? N. S. A.

13. FATHER'S NAME Eson Mumford

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS Mrs Geo T. King Eastport Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause (a) Myocarditis ?

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

93d (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) none

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-5, 1950, to 9-9, 1950, that I last saw the deceased alive on 9-9, 1950, and that death occurred at 2.40 P m., from the causes and on the date stated above.

SIGNATURE C M Lowe (Degree or title) M. D. ADDRESS 90 Cathedral St, Annapolis Md DATE SIGNED 9-9-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF Sept 13-50 NAME OF CEMETERY OR CREMATORY St Annes LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Sept. 13, 1950 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

XLX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

(1)

17

RECEIVED
SEP 14 1950
BUREAU T. S

08914

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (In this place) 20 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Herald Harbor

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Herald Harbor, Crownsville RD.
STREET ADDRESS (If rural give location) Chestnut Trail

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) (Last) MAINZ

4. DATE OF DEATH: (Month) Sept. (Day) 23 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Dec. 28, 1877

9. AGE last birthday: 72 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY? Building

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN MAINZ Sr.

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Reisterstown
Mrs. Lillian E. Forwood-Rt. 1, Box 50,

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

443X **Immediate cause** (a) Acute Dilatation of Heart — Sudden

932 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vascular Disease — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John McCaffrey M.D., Deputy Medical Examiner, Annapolis Md 9/23/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 9/27/50 | NAME OF CEMETERY OR CREMATORY: Woodlawn Cem. | LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REG. 9/25/50 | REGISTRAR'S SIGNATURE H.W. Hedrick Dep | 24. FUNERAL DIRECTOR: Wm. J. Sichner & Sons | ADDRESS: Balto. Md.

308 V9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

08915

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, near Laurel
LENGTH OF STAY (in this place): 24 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Hospital of District Tr. Sch.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland D.C. — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, near Laurel
STREET ADDRESS (If rural, give location): ----

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | Andrew | C. | McCubbin | | 9 | 12 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | 9-8-1887 | 63 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Feeble-minded | None | Virginia | U.S.A. |

13. FATHER'S NAME: William McCubbin

14. MOTHER'S MAIDEN NAME: Anna - - -

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| 0 | 0 | B.P.W., Washington, D. C. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cirrhosis of liver | 2 - 5 yrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cholelithiosis | ? |
| | (c) Emaciation | 1 year |

584X
126

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 0 | 0 | Yes ☒ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| --- | | ---- | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| ---- | | | m. | | |

22. I hereby certify that I attended the deceased from July 26, 1949, to Sept. 12, 1950, that I last saw the deceased alive on 9-12, 1950, and that death occurred at 3:40 p.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Benjamin E. Hodge | M.D. | District Training School Jessup, Md. | 9-13-50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 14 | Dist H School | Laurel Md. |

| DATE RECD BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Sept 14 | Clara Harlow | Raymond Jones | Laurel Md |

XVX94

RECEIVED
OCT 6 1950
BUREAU V. S

08916

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; MARYLAND; LENGTH OF STAY (in this place) 4 mon; HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home, West St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Alexandria; STREET ADDRESS (If rural, give location) 3317 Valley View

3. NAME OF DECEASED (Type or Print): (First) Ernest (Middle) Hudson (Last) Merrick

4. DATE OF DEATH: (Month) Sept (Day) 4 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3/17/60±

9. AGE last birthday: 90± yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping Business

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Xneia Ohio

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Merrick

14. MOTHER'S MAIDEN NAME: Harriet

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Son- Wm M. Merrick

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 X **Immediate cause** (a) Cerebral Vascular Accident — Interval Between Onset and Death: 1 wk

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Arteriosclerosis — —

(c)

II. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —; (CITY OR TOWN): —; (COUNTY): —; (STATE): —

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: — — — — —

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 9/1/, 1950, to 9/4/, 1950; that I last saw the deceased alive on 9/3/, 1950, and that death occurred at 7:55P m., from the causes and on the date stated above.

SIGNATURE: Frank M. Shipley (Degree or title) M.D. ADDRESS 63 College Ave Annapolis, Md. DATE SIGNED 9/4/50

23. ~~BURIAL~~, CREMATION, ~~REMOVAL (Specify)~~: DATE THEREOF 9-6-50; NAME OF CEMETERY OR CREMATORY: Cedar Hill; LOCATION (City, town, or county): Pri Geo. Co.; (State): Md.

DATE REC'D BY LOCAL REG.: Sept. 4, 1950

REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Cunningham Funeral Home; ADDRESS: Alexandria, Va.

XVX 54

VS. A15

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1950
BUREAU V. S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08917

FILM No. G 128 OCT 6 1950

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 Calvert St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 63 Calvert St

3. NAME OF DECEASED (Type or Print): (First) Violetta (Middle) (Last) Moore

4. DATE OF DEATH: (Month) Sept. (Day) 29 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: April 12, 1894

9. AGE last birthday: 55 yrs. If under 1 year: Months 5 Days 17 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: B. S. Moore

14. MOTHER'S MAIDEN NAME: Eliza Reddick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Blanche M. Howard, Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Stomach — Interval between onset and death: ~~3 m~~ 6 mon.

151X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b)

46b (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 10, 1950, to Sept. 29, 1950, that I last saw the deceased alive on Sept 29, 1950, and that death occurred at 1 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Theodore G. Johnson M.D. ADDRESS 40 Northwest Street DATE SIGNED Sept 29 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Oct 2, 1950 | NAME OF CEMETERY OR CREMATORY: Brewer Hill | LOCATION (City, town, or county) (State): Annapolis, Md

DATE REC'D BY LOCAL REG.: Oct. 2, 1950 | REGISTRAR'S SIGNATURE: W. D. Lynch | 24. FUNERAL DIRECTOR: J B Johnson | ADDRESS: Annapolis, Md.

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VS. A15

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08918

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 111 15th Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
STREET ADDRESS (If rural, give location) 111 15th Avenue

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) A. (Last) Moran

4. DATE OF DEATH (Month) September (Day) 26, (Year) 1950

5. SEX male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Apr. 11, 1880

9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Stationary Engineer

10b. KIND OF BUSINESS OR INDUSTRY Ft. Meade, Md.

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joseph A. Moran

14. MOTHER'S MAIDEN NAME Roberta King

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-09-4204

17. INFORMANT AND ADDRESS Mrs. Elizabeth Moran, 111 15th Ave. Brooklyn Park

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 420.1 | Immediate cause | (a) Acute Coronary Occlusion | 2 min. |
| 61 | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary artery sclerosis and generalized arteriosclerosis | 4-5 yr |
| | | (c) Diabetes Mellitus | 1 yr. |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947, 19....., to Sept 26th, 1950, that I last saw the deceased alive on 9-21-50, 19....., and that death occurred at 6:55 P m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) MD. ADDRESS 642 N. [illegible] DATE SIGNED 9-22-50

23. BURIAL, CREMATION REMOVAL (Specify) burial

DATE THEREOF 9/30/50

NAME OF CEMETERY OR CREMATORY Holy Cross

LOCATION (City, town, or county) (State) Brooklyn Park, Maryland

DATE REC'D BY LOCAL REG. 9-27-50

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Wm. Cook, Inc. ADDRESS 1217 St. Paul Street

35698

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VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08919

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 167 Green

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 167 Green

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) I. (Last) Munroe
4. DATE OF DEATH: (Month) Sept (Day) 1 (Year) 1950
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): ~~MARRIED~~
8. DATE OF BIRTH: Aug 30-1872
9. AGE last birthday: 78 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): New Brunswick N. J.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Joseph B. Durant
14. MOTHER'S MAIDEN NAME: Francis Goodwin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Mrs Elizabeth Monroe Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Thrombosis | 2 days |
| 443X 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive Cardio-Vascular Disease | 3 yrs. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:
(CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour): m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-28-, 1950, to 9-1-, 1950, that I last saw the deceased alive on 9-1-, 1950, and that death occurred at 4:25 p m., from the causes and on the date stated above.

SIGNATURE: James A. Stanton (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 9-2-50

23. BURIAL, CREMATION, REMOVAL (Specify): — DATE THEREOF Sept 4-50 — NAME OF CEMETERY OR CREMATORY St Annes — LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Sept. 4, 1950 — REGISTRAR'S SIGNATURE W. J. Lynch

24. FUNERAL DIRECTOR John M. Sayler Sons ADDRESS Annapolis Md.

RECEIVED
SEP 6 1950
BUREAU F. I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08920

# CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover, Rural
LENGTH OF STAY (in this place) 73 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Near - Dorsey

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hanover, Rural
STREET ADDRESS (If rural, give location) near Dorsey

3. NAME OF DECEASED (Type or Print): (First) Lavinia (Middle) (Last) Hooker
4. DATE OF DEATH: (Month) Sept. (Day) 20 (Year) 1950

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow.
8. DATE OF BIRTH: Oct. 3rd 1876
9. AGE last birthday: 73 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Hsf.
11. BIRTHPLACE (State or foreign country): Prince Ges. Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David G. Mallhews
14. MOTHER'S MAIDEN NAME: Sarah E. Brewer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS: Marie Hooker Brogden, Hanover

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X — Immediate cause (a) Cerebral Haemorrhage — Interval Between Onset and Death: 4 yrs.

Antecedent cause(s)

83a — Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension & Arterio-sclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1946, 19..., to Sept. 20, 1950, that I last saw the deceased alive on Sept. 1st, 1950, and that death occurred at 12:50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Frank Shipley, M.D., Savage, Md. 9/20/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 9-23-1950
NAME OF CEMETERY OR CREMATORY: St. Marks
LOCATION (City, town, or county): Harmans (State): Md.

DATE REC'D BY LOCAL REG.: Sept 23rd 1950
REGISTRAR'S SIGNATURE: R.W.
24. FUNERAL DIRECTOR: Mrs. Katie R. Williams / Schroeder St.
ADDRESS 322

08921

# MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 20

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A. |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harwood — LENGTH OF STAY (in this place) 20 yrs | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harwood |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural | STREET ADDRESS (If rural give location) Rural |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) RUDOLPH | (Middle) | (Last) OWENS | 4. DATE OF DEATH | (Month) Sept (Day) 20 (Year) 1950 |
| 5. SEX male | 6. COLOR OR RACE negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH unknown | 9. AGE last birthday about 78 yrs. | If under 1 year Months / Days; If under 24 hrs. Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY Farm | 11. BIRTHPLACE (State or foreign country) Drury, Md | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Elijah Owens | 14. MOTHER'S MAIDEN NAME Margaret Colbert | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. none | 17. INFORMANT John Henry Owens | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 331x | Immediate cause | (a) Cerebral accident | sudden |
| 93d | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive vascular disease | unknown |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |

| | | |
|---|---|---|
| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John M. Laffey M.D. | Deputy Medical Examiner | Annapolis Md | 9/20/50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Sept 24, 1950 | NAME OF CEMETERY OR CREMATORY Daniel Star | LOCATION (City, town, or county) (State) Owensville Md |
| DATE REC'D BY LOCAL REG. Sept 23rd 1950 | REGISTRAR'S SIGNATURE M. Clayton Dep Local Reg | 24. FUNERAL DIRECTOR T. A. Hardesty & Son | ADDRESS |

866

RECEIVED
SEP 23 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

018923

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY A. A. | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Co General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 45 Madison

3. NAME OF DECEASED (Type or Print): (First) Julia (Middle) M. (Last) Puckett
4. DATE OF DEATH: (Month) 9 (Day) 16 (Year) 1950
5. SEX F. 6. COLOR OR RACE W. 7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)
8. DATE OF BIRTH 5-27-1877 9. AGE last birthday 73 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home wife 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Charles Co Md. 12. CITIZEN OF WHAT COUNTRY U. S. A.
13. FATHER'S NAME Wilfred Jackson
14. MOTHER'S MAIDEN NAME Mary J. Jamison
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS Mrs Archer L. Robinson Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Brain abcess — 1 week

196X 55d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of left ethmoid — 1 year

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive heart disease

19a. DATE OF OPERATION Sept 8 1950 | 19b. MAJOR FINDINGS OF OPERATION Carcinoma of ethmoid | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Sept., 1950, to 16 Sept, 1950 that I last saw the deceased alive on 16 Sept, 1950, and that death occurred at 10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Irving L. Ocha M.D. 51 Southgate Ave Ann. 18 Sept 50

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) | DATE THEREOF 9-18-1950 | NAME OF CEMETERY OR CREMATORY St Mary's | LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Sept. 19, 1950 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

RECEIVED
SEP 20 1950
BUREAU

08924

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Not BC

Reg. Dist. No. 23

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: P.O. Glen Burnie — LENGTH OF STAY (in this place): 4 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: I ave. Marley Heights.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore.
STREET ADDRESS (If rural, give location): 4504 - Keswick Rd.

3. NAME OF DECEASED (Type or Print): (First) Leroy (Middle) B. (Last) Satterfield
4. DATE OF DEATH (Month) Sept. (Day) 15 (Year) 1950
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed.
8. DATE OF BIRTH: 5/3/1896
9. AGE last birthday: 54 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver.
10b. KIND OF BUSINESS OR INDUSTRY: DELIVERY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: GENEVE MASON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. - ✓ (If year, give war or dates of service) 1918
16. SOCIAL SECURITY No.:
17. INFORMANT AND ADDRESS: Mr. George Satterfield (Son).

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

148 X Immediate cause (a) Cancer of throat. — 5 months?

Antecedent cause(s)

45 f Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pulmonary T.B. — 1 year?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1st, 1950, to Sept. 15, 1950, that I last saw the deceased alive on Sept. 13, 1950, and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE: Gustave H. Fowler MD. (Degree or title) ADDRESS: Glen Burnie, 6 - Md. DATE SIGNED: 9/15/50.

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE: SEPT 1950 — NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL — LOCATION (City, town, or county): GLE BURNIE (State): MD

DATE REC'D BY LOCAL REG.: Sept 16 1950 — REGISTRAR'S SIGNATURE: L. J. De Alba — 24. FUNERAL DIRECTOR: W Dugleton — ADDRESS:

420-50

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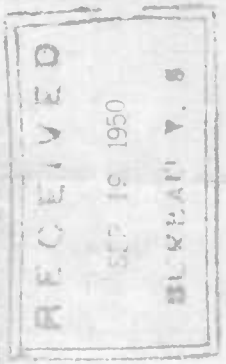
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Query answer from Dr. Faubert re cause of death: " Primary cause "as per stated."

9-26-50 -ams



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

18925

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pasadena Md.
LENGTH OF STAY (in this place): 4 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Boulevard Park

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Boulevard Park, Pasadena Md.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) E (Last) Scott

4. DATE OF DEATH: (Month) Sept. (Day) 2 (Year) 19 I950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: June 23, I862

9. AGE last birthday: 88 yrs. — If under 1 year: Months 2, Days 10 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own house

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander Slaysman

14. MOTHER'S MAIDEN NAME: Sallie West

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr.W.C.Scott-6I8 Debaugh Ave.-Towson Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Heart failure | 6 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) generalized arteriosclerosis | unknown |
| | (c) Hypostatic pneumonia | unknown |

447 X
97

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 4, 1950, to Sept 2, 1950, that I last saw the deceased alive on Sept 2, 1950, and that death occurred at 3:15 P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Ronald W. McLaughlin | M.D. | Pasadena, Md. | Sept. 2. 1950 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-5-1950 | Baltimore Cemetery | E. North Ave., Balto. Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-4-50 | R. W. Hedrick M.R.G. | George J. Ruth, Inc. | I735 Harford Avenue |

08926

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 37 Murry Ave

3. NAME OF DECEASED (Type or Print): (First) OSCAR (Middle) (Last) SHACKS

4. DATE OF DEATH: (Month) Sept 14, (Day) 50, (Year) 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Aug. 3, 1880

9. AGE last birthday: 70 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner

10b. KIND OF BUSINESS OR INDUSTRY: Dry Goods Store

11. BIRTHPLACE (State or foreign country): Lithuania

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Meyer Irving Shacks

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Mrs Ida Shacks 37 Murry Ave. Annapolis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | Sudde |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary Sclerosis | 4 yrs |
| 4/20.1 932 | (c) Myocardial Chr. | 5 yrs |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension — 4 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1946, to Sept 14, 1950, that I last saw the deceased alive on Sept 14, 1950, and that death occurred at 7 A m., from the causes and on the date stated above.

SIGNATURE: Geo C Basil (Degree or title) M D ADDRESS: Annapolis Md DATE SIGNED: 9.15.50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 9-15-50

NAME OF CEMETERY OR CREMATORY: Kneseth Israel Cemetery

LOCATION (City, town, or county) (State): Parole Nr Annapolis, Md.

DATE REC'D BY LOCAL REG.: Sept. 15, 1950

REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR ADDRESS: B.L. Hopping and Son Annapolis, Maryland

15663

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SEP 18 1950
BUREAU V. S

08927

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie — LENGTH OF STAY (in this place): 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Open air electric Ritchie Highway

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Massachusetts — COUNTY: Hampton
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Springfield
STREET ADDRESS (If rural, give location): 23 Springstreet

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) Casimir (Last) Sharby
4. DATE OF DEATH: (Month) Sept. (Day) 11 (Year) 1950
5. SEX: M
6. COLOR OR RACE: W
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) married
8. DATE OF BIRTH: 11/2/1876
9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Railroad Man
10b. KIND OF BUSINESS OR INDUSTRY: 003-14-9215
11. BIRTHPLACE (State or foreign country): Sutton, Prov. of Quebec
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Raoul Sharby
14. MOTHER'S MAIDEN NAME: Pellagie Daudlin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: 003-14-9215
17. INFORMANT AND ADDRESS: Mrs. J. S. Sharby (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 9 days

331X Antecedent cause(s) (b) General arterio sclerosis — ?

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/3/50, 19, to 9/11, 1950, that I last saw the deceased alive on 9/10, 1950, and that death occurred at 8 A. m., from the causes and on the date stated above.

SIGNATURE: Gustave H. Fauhen MD. (Degree or title) — ADDRESS: Glen Burnie Md. — DATE SIGNED: 9/11/50

23. BURIAL, CREMATION REMOVAL (Specify) — DATE: 9-11-50 — NAME OF CEMETERY OR CREMATORY: TO KEENE-NEW HAMPSHIRE — LOCATION (City, town, or county) (State): SAME

DATE REC'D BY LOCAL REG.: 9/11/50 — REGISTRAR'S SIGNATURE: H.W. Hedrick Dep. — 24. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St Paul (2)

XV X47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

08928

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Churchton
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Churchton
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Henry (Last) Simmons
4. DATE OF DEATH (Month) Sept. (Day) 4 (Year) 1950
5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: Apr. 4 1874
9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: Owner FARMER
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Robert H. Simmons
14. MOTHER'S MAIDEN NAME: Mary Stallings
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT AND ADDRESS: Alvin Simmons Churchton Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Infarction

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriscleroitic C-V. disease

93d

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9.1.50, 19..., to 9.4.50, 19.50, that I last saw the deceased alive on 9.1.50, 19.50, and that death occurred at 3 A.M. m., from the causes and on the date stated above.

SIGNATURE: B. L. Grant M.D. (Degree or title) ADDRESS: Shady Side, Md. DATE SIGNED: 9.4.50

23. BURIAL, [redacted] — DATE THEREOF: Sept 6, 1950 — NAME OF CEMETERY OR CREMATORY: Quaker Vern — LOCATION (City, town, or county) (State): Galesville Md

DATE REC'D BY LOCAL REG.: Sept 4 — REGISTRAR'S SIGNATURE: J. B. Hunt
24. FUNERAL DIRECTOR: J. A. Hardesty & Son — ADDRESS: Galesville Md

000 VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 6 1950
BUREAU V. I

08929

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) N.O.A.
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
STREET ADDRESS (If rural give location) Broadneck Road

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) (Last) Smith
4. DATE OF DEATH (Month) Sept. (Day) 13 (Year) 1950
5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH Sept. 1 1902
9. AGE last birthday 48 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stubor, Bridge Con. Co.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Earleigh Hughes A.A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Nathaniel Smith
14. MOTHER'S MAIDEN NAME Mary Jane, Robinson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.
17. INFORMANT Albert Smith (Brother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

902.8 Immediate cause (a) Hemorrhage — sudden

1860 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fracture of Skull — sudden

(c) Fracture of ileum and sacrum (right)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture right elbow joint

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, [illegible]) INJURY New Severn River Bridge
(CITY OR TOWN) near Annapolis (COUNTY) A.A. (STATE) Md
TIME OF INJURY (Month) Sept. (Day) 13, (Year) 1950 (Hour) 9:30 A m.
INJURY OCCURRED While at work ☒ Not while at work ☐
HOW DID INJURY OCCUR? Fell about 25 feet inside a coffer-dam.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED Sept. 15, 1950.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 17, 1950
NAME OF CEMETERY OR CREMATORY Mt Calvary
LOCATION (City, town, or county) Arnold (State) Md.

DATE REC'D BY LOCAL REG. Sept. 16, 1950
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR J.B. Johnson ADDRESS Annapolis, Md

988V9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
SEP 20 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

08930

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Haven (Pasadena Rural) | LENGTH OF STAY (in this place) 4 year.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastshore Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PASADENA RURAL
STREET ADDRESS (If rural give location) EAST SHORE ROAD, GREEN HAVEN.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Lloyd | L. E. | Smith. | 9 | 4 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | White | Widowed | 8/25/91 | 59 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Assistant Engineer (Boat) | Boat. | San Francisco, Calif. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Smith | Ellevena Roach |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | 081-09-0501 | Albert J. Reitmeier, 50 Vermillion Ave New York, N.Y. |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| 420.1 **Immediate cause** (a) Coronary Occlusion | Sudden. |
| 94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) | |
| (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | | Yes ☐ No ☑ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| — | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Gustave K. Faucher M.D. | Attending medical examiner. | Glen Burnie, Md. | 9/4/50. |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| BURIAL | SEPT. 6 1950 | GLEN HAVEN | GLEN BURNIE | MD |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9/5 | L. J. Dalla | Thomas W. Singleton | Glen Burnie Md. |

12051

RECEIVED
SEP 7 1950
BUREAU V. S

08931

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Crownsville, Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balt.City |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital | STREET ADDRESS (If rural, give location): 1721 W. Lanvale Street |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Flora | (Middle) Anna | (Last) Spencer | 4. DATE OF DEATH | (Month) 9/11/50 (Day) (Year) 19 |
| 5. SEX: female | 6. COLOR OR RACE: colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed | 8. DATE OF BIRTH: 7/17/07 | 9. AGE last birthday: 43 yrs. | If under 1 year: Months / Days; If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic | 10b. KIND OF BUSINESS OR INDUSTRY: none | 11. BIRTHPLACE (State or foreign country): Keysville, Va. | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME: Alexander Watkins | 14. MOTHER'S MAIDEN NAME: Elizabeth Rice Watkins | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS: Hospital Records | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 442X Immediate cause | (a) Cardio-Renal Disease | known since 8/28/50 |
| 131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

| | | |
|---|---|---|
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Psychosis with Cardio-Renal Disease | known 8/28/5 |
| 19a. DATE OF OPERATION: none | 19b. MAJOR FINDINGS OF OPERATION: none | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify): none | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour): none m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? none |

22. I hereby certify that I attended the deceased from 8/28/50, 19....., to 9/11/50, 19....., that I last saw the deceased alive on 9/11/50, 19....., and that death occurred at 3:15 a.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Jacob Morgenstern M.D. | | Crownsville, Md. | 9/11/50 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Sept 15, 1950 | NAME OF CEMETERY OR CREMATORY: Mt. Calvary | LOCATION (City, town, or county) (State): Cedar Hill, Md |
| DATE REC'D BY LOCAL REG.: 9-13-50 | REGISTRAR'S SIGNATURE: L | 24. FUNERAL DIRECTOR: Mrs Katie R Williams | ADDRESS: Schroeder St |

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

08932

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 79 Conduit Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 79 Conduit St.

3. NAME OF DECEASED (Type or Print): (First) Julia (Middle) (n) (Last) STEVENS

4. DATE OF DEATH: (Month) Sept. (Day) 28, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Specify)

8. DATE OF BIRTH: 9-22-1878

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. ~~KIND OF~~ BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles David Stevens

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Cora Businsky - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Tongue c

141X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 45b (b) Extension to mandible, maxilla, et — 2 yrs (?)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uncertain

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ~~a.m.~~ p.m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1950, to Sept 28, 1950, that I last saw the deceased alive on Sept 28, 1950 and that death occurred at 10.40 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Maurice J. Klaware, MD Annapolis, Md 9/29/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify): Burial

DATE THEREOF: 10-1-1950

NAME OF CEMETERY OR CREMATORY: Cedar Bluff

LOCATION (City, town, or county) (State): Annapolis Md.

DATE REC'D BY LOCAL REG.: Oct. 1, 1950

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: John H. Taylor & Son ADDRESS: Annapolis, Md.

RECEIVED
OCT 3 1950
BUREAU V. S

08934

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 4 Cornhill

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Fred | L. | Stone | 9 | 29 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | | 4-20-1874 | 76 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House painter | Painting | Annapolis Md | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Richard Stone | Frances M. Potter |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | | Cecelia M. Stone Annapolis Md. |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| Immediate cause (a) Cerebral Hemorrhage | 2 wks. |
| 331X 83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension | unkn. |
| (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis generalized | unkn. |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Sept 14, 1950, to Sept 29, 1950, that I last saw the deceased alive on Sept 29, 1950, and that death occurred at 11 A.M., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Geo. C. Basil | M. D. | Annapolis Md | 9. 30 50 |

| 23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 10-2-50 | St Mary's | Annapolis Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct. 2, 1950 | [signature] | John M. Taylor Son | Annapolis Md. |

340V9

RECEIVED
OCT 3 1960
BUREAU V. S

08935

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co. General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 114 Market St.

3. NAME OF DECEASED (Type or Print): (First) AMANDA (Middle) M. (Last) STRANGE

4. DATE OF DEATH: (Month) 9 (Day) 5 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify)

8. DATE OF BIRTH: 9-2-1865

9. AGE last birthday: 85 yrs. If under 1 year: Months; If under 24 hrs.: Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| 260x Immediate cause | (a) Coronary Occlusion | 2 days |
| 61 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive Cardio-Vascular Disease | 10 yrs. |
| | (c) Diabetes mellitus | 50 yrs. |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1947, to 9-5-, 1950 that I last saw the deceased alive on 9-5, 1950, and that death occurred at 8:00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James D. Martin M.D. Annapolis, Md. 9-7-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify): DATE THEREOF 9-8-50; NAME OF CEMETERY OR CREMATORY St. Anne's; LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Sept. 7, 1950

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: John M. Taylor ADDRESS Annapolis Md.

RECEIVED
SEP 11 1950
BUREAU V. M.

08936

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Bayside Beach (Pasadena P.O.)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred: Lot #23 Harbor Road

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Bayside Beach (Pasadena P.O.)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lot #23 Harbor Road
(If rural, give LOCATION)

2.(a) If veteran, name war: None

**3.(a) FULL NAME:** LENA MARY STROBACK

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widowed |

6.(b) Name of husband or wife: Joseph Stroback

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12, 1875

**8. AGE:** Years: 75 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Housewife (ret.)

11. Industry or business: Own Home

FATHER
12. Name: Otto Conrad
13. Birthplace:

MOTHER
14. Maiden name: Unknown
15. Birthplace:

16. Informant: Mr. Albert Stroback
Address: Bayside Beach (Pasadena P.O.)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 29, 1950 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brooklyn R.F.D.

18. Funeral director: R.V. Singleton
Address: Glen Burnie, Md.

19. 9/29 1950 (Date rec'd by registrar) L. J. DeAlba Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/27 1950 at 3:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1950 to Sept. 27 1950 and that I last saw her alive on 9/20 1950

| Immediate cause of death | DURATION |
|---|---|
| Heart Failure | 1 day |
| Due to Degenerative Cardio Vascular Disease | 5 years |
| Due to Arteriosclerotic Cardio Vascular Disease | 5 years |

Other conditions: 422.1 93d (Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Brady Smith M.D. M. D. or other

Address: Rebecca Beach, Md. Date signed: 9/27/50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

M

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RECEIVED
SEP 30 1950
BUREAU

08937

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A.A.Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md. LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 144 PRINCE GEORGE St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.
STREET ADDRESS (If rural, give location) 144 PRINCE GEORGE St.

3. NAME OF DECEASED (Type or Print) (First) FLORA (Middle) (Last) TARANTINO
4. DATE OF DEATH (Month) 9 (Day) 12 (Year) 1950
5. SEX F
6. COLOR OR RACE W
7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 8/19/1873
9. AGE last birthday 77 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) ~~New York~~ ITALY
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME GIOVANI PENNINO
14. MOTHER'S MAIDEN NAME CARMELA LAURITO
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS HENRY J. TARANTINO ANNAPOLIS MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis — Several years.

94a (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1940, to Sept 12, 1950, that I last saw the deceased alive on Sept 12, 1950, and that death occurred at 11 A m., from the causes and on the date stated above.

SIGNATURE George C. Basil (Degree or title) M. D. ADDRESS Annapolis Md DATE SIGNED 9-12-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 9/15/50 NAME OF CEMETERY OR CREMATORY St. MARYS LOCATION (City, town, or county) (State) ANNAPOLIS, MD.

DATE REC'D BY LOCAL REG. Sept. 15, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylorison ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 18 1950
BUREAU V. S

08933

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 2073 West St.

3. NAME OF DECEASED (Type or Print) (First) CHARLES (Middle) COLUMBUS (Last) TAYMAN

4. DATE OF DEATH (Month) Swpt. (Day) 27, (Year) 1950 19

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Aug. 11, 1886
9. AGE last birthday 64 yrs. If under 1 year Months 1 Days 8 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming - Tenant
10b. KIND OF BUSINESS OR INDUSTRY Tobacco Farm
11. BIRTHPLACE (State or foreign country) Prince George County, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles R. Tayman
14. MOTHER'S MAIDEN NAME Rose E. Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT AND ADDRESS Mr Charles Robert Tayman (Son) Chesterfield rd. Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Peritonitis - Generalized | 48 hrs. |
| 585 K Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Gangrene & rupture of the Gall | |
| 127 b | (c) bladder | 48. |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION 9/26/50
19b. MAJOR FINDINGS OF OPERATION Gangrene & rupture of the Gall-bladder
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) no
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/25/50, 19..., to 9/27/50, 19..., that I last saw the deceased alive on 9/27/50, 19..., and that death occurred at 1:20 P. m., from the causes and on the date stated above.

SIGNATURE Albert Friedman (Degree or title) M.D. ADDRESS Annapolis, Md DATE SIGNED 9/27/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF SEPT. 30, 1950
NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery
LOCATION (City, town, or county) (State) Upper Marlboro, Maryland

DATE REC'D BY LOCAL REG. Sept. 29, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR B.L. Hopping and Son ADDRESS Annapolis, Maryland

000VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 30 1950
BUREAU V. S

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08938

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 2 yrs. 6mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City, Maryland
STREET ADDRESS (If rural, give location) 1604 W. Mulberry Street

3. NAME OF DECEASED (Type or Print) (First) Allie (Middle) (Last) Thomas
4. DATE OF DEATH (Month) 9 (Day) 8 (Year) 1950

5. SEX female
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 1885 ?
9. AGE last birthday 65? yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 41/2x Immediate cause | (a) Cardio-Renal Disease | known since 2/23/48 |
| 131a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) Psychosis With Cerebral Arteriosclerosis | known since 2/23/48 |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/23, 1948, to 9/8, 1950, that I last saw the deceased alive on 9/8, 1950 and that death occurred at 5:00 P.m., from the causes and on the date stated above.

SIGNATURE Jacob Hoyerstein M.D. (Degree or title) ADDRESS Crownsville State Hospital, Maryland DATE SIGNED 9/9/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9/13/50
NAME OF CEMETERY OR CREMATORY Mt Calvary
LOCATION (City, town, or county) (State) A. A. Co., Md

DATE REC'D BY LOCAL REG. 9/11/5
REGISTRAR'S SIGNATURE A. W. Hedrich
24. FUNERAL DIRECTOR ISAIAH L. BROWNSON ADDRESS 1080 Montgomery St

JCL

52086

Dr Basil

08939

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold P. O.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Nina (Middle) Miller (Last) Thum
4. DATE OF DEATH (Month) Sept (Day) 2 (Year) 1950
5. SEX F
6. COLOR OR RACE W.
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH June 1st 1864
9. AGE last birthday 86 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Charleston W. Va
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Samuel Miller
14. MOTHER'S MAIDEN NAME Helen Quarrier
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS Mrs Amos F Hutchins Arnold Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — Aug. 25

331X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Ph Hemiplegia

83a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Arteriosclerosis — unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 25, 1950, to Sept 2, 1950, that I last saw the deceased alive on Sept 2, 1950, and that death occurred at 5 p m., from the causes and on the date stated above.

SIGNATURE George A. Basil (Degree or title) M. D. ADDRESS Annapolis Md DATE SIGNED 9-3-50

23. ~~BURIAL, CREMATION~~ REMOVAL ~~(Specify)~~ DATE THEREOF 9/4/50 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) Charleston W. Va.

DATE REC'D BY LOCAL REG. Sept. 4, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

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M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Millersville
LENGTH OF STAY (in this place) 3 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Millersville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Edward (Middle) L (Last) Todd

4. DATE OF DEATH (Month) Sept (Day) 22 (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH Sept 1 1869

9. AGE last birthday 81 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper

10b. KIND OF BUSINESS OR INDUSTRY Department store

11. BIRTHPLACE (State or foreign country) Omaha, Nebraska.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Herbert L. Todd

14. MOTHER'S MAIDEN NAME Mary C. Hardy.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No. 577 20 1515

17. INFORMANT AND ADDRESS Walter H. Todd, Crownsville Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 18 Hrs.

443X Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vascular disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 3, 1950, to Sept 22, 1950, that I last saw the deceased alive on Sept 22, 1950, and that death occurred at 10:45 P m., from the causes and on the date stated above.

SIGNATURE Edward G Thewitt (Degree or title) M.D. ADDRESS Gambrills DATE SIGNED 9-22-50

23. BURIAL, CREMATION REMOVAL (Specify) DATE Sept 25-1950 NAME OF CEMETERY OR CREMATORY Congressional LOCATION (City, town, or county) Washington DC (State)

DATE REC'D BY LOCAL REG. 9-23-50 REGISTRAR'S SIGNATURE M. E. Joyce

24. FUNERAL DIRECTOR Geo W Wise Co. ADDRESS Wash. DC

15663

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Evidence for addition on cause of death shown on:

FILM No. G 128 OCT 27 1950

08941

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bay Side Beach
LENGTH OF STAY (In this place) 3 hours
HOSPITAL OR INSTITUTION OR STREET ADDRESS Lake Drive

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore - 24
STREET ADDRESS 819 Fagley (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) CALVIN (Middle) FREDERICK (Last) WEAVER
4. DATE OF DEATH (Month) Sept. (Day) 4 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH Oct. 19, 1916
9. AGE last birthday 34 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer
10b. KIND OF BUSINESS OR INDUSTRY Canton R.R.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Frederick Weaver
14. MOTHER'S MAIDEN NAME Elizabeth Law
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Army World War II
16. SOCIAL SECURITY NO. 212-07-2987
17. INFORMANT Harry Weaver

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

850.8 Immediate cause (a) Drowning

172 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay near Bay Side Beach (CITY OR TOWN) (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 4, 1950 5:30 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Was out fishing and strong wind squall capsized boat. (10-27-50 - ams)

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy, M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 9-6-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9-8-1950
NAME OF CEMETERY OR CREMATORY Oak Lawn Cem
LOCATION (City, town, or county) Eastern Ave. - Balto. (State) Md.
DATE REC'D BY LOCAL REG. 9/7/50
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR John C. Miller Inc. ADDRESS 2435 E. Olney St.

32247

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

Evidence for change of age shown on:

**MARYLAND STATE DEPARTMENT OF HEALTH**

2411 N. Charles Street, Baltimore

08942

FILM No. G 123 SEP 18 1950

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 36 hours; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Balt. City; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City; STREET ADDRESS (If rural, give location) 1572 Richland Street

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Arthur (Last) Webster

4. DATE OF DEATH: (Month) 9/3/50 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married

8. DATE OF BIRTH: August 17 1895 Not known

9. AGE last birthday: 55 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not known Cabaret

10b. KIND OF BUSINESS OR INDUSTRY: Cafe Jel Cone Junk

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Not known John A. Webster

14. MOTHER'S MAIDEN NAME: Emma ? Notknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) ~~No~~ ~~***

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

08943

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Aa — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 107 McKendree

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Aa.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 107 McKendree

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| William | Henry | Westphal | Sept | 10 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M. | W. | | 1-16-1878 | 72 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Blacksmith | Horseshoeing Shop | Annapolis | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Westphal | Elizabeth Musterman |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| | | Mabel R. Westphal Annapolis Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intestinal Bleeding — several hours

154K / 46d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma of Rectum — 2½ yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| — | — | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| — | | | m. | | — |

22. I hereby certify that I attended the deceased from Feb, 1950, to Sept, 1950, that I last saw the deceased alive on Sept 10, 1950, and that death occurred at 6P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Frank M. Shipley | M.D. | 63 College Ave Annapolis | 9/11/50 |

| 23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| | Sept 14-50 | National | Annapolis | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Sept. 13, 1950 | [signature] | John M. Taylor & Son | Annapolis Md. |

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

08944

# MARYLAND STATE DEPARTMENT OF HEALTH
# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GREEN GABLES
LENGTH OF STAY (in this place) 3 MOS
HOSPITAL OR INSTITUTION OR STREET ADDRESS RURAL, PASADENA, P.O

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE - 23
STREET ADDRESS (If rural give location) 2654 Lauretta Ave.

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) HARMON (Last) WEVER
4. DATE OF DEATH (Month) Sept. (Day) 10 (Year) 1950

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed
8. DATE OF BIRTH MAR. 16 1888
9. AGE last birthday 62 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN, PUMPING, STA.
10b. KIND OF BUSINESS OR INDUSTRY WATER SUPPY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME JOHN J. WEVER
14. MOTHER'S MAIDEN NAME CAROLINE V. WEEDON,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. no
17. INFORMANT Mr. William W. Wever 2654 Lauretta Ave.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 420.1 | Immediate cause | (a) Coronary occlusion | sudden |
| 94a | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary sclerosis | about 2 years |
| | | (c) | |

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy MEDICAL ADDRESS Examiner, Annapolis, Md DATE SIGNED 9/10/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 9/13/50
NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.
LOCATION (City, town, or county) (State) A. A. Co., Md.

DATE REC'D BY LOCAL REG. 9/11/50
REGISTRAR'S SIGNATURE A. W. Hedrich JCL
24. FUNERAL DIRECTOR Wm. J. Tickner & Sons ADDRESS Balto. Md.

31698

# MARYLAND STATE DEPARTMENT OF HEALTH

08945

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville | LENGTH OF STAY (in this place) 1 yr., 3 mon
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Dorchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Williamsburg
STREET ADDRESS (If rural, give location) ✓

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Jesse | James | White | 9 | 30 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Married | 10/11/96 | 53 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World W. I
16. SOCIAL SECURITY NO.: ---------
17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) General Paresis | 6/19/49 |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | Known to us since adm. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from June 12, 1949, to Sept. 30 1950, that I last saw the deceased alive on Sept. 30, 1950, and that death occurred at 5:25 a.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Jesse Marquette M.D. | | Crownsville, Maryland | 9/30/50 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/50 | Fredericksburg | Fredericksburg Maryland. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Sept 30, 1950 | R. M. Joyce | J. J. Frampton Son | Fredericksburg Md. |

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

08922

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: D. C. — COUNTY: Anne Arundel |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - near Laurel — LENGTH OF STAY (in this place): 21 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, near Laurel, Md. |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Hospital, District Training School, Laurel, Md. | STREET ADDRESS (If rural, give location): ----- |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Arthur | - | Williams | Sept. | 12 | 1950 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | 3-1-1887 | 63 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Feeble-minded | 0 | Washington, D. C. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Not known | Not known |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS |
|---|---|---|
| No | 0 | B.P.W., Washington, D. C. |

## 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Embolus | 15 min. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Thrombosis of right saphenous vein | 1 mo. |
| | (c) Chronic rt. lymphangeitis | 3 yrs. |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Imbecile | Life |

693.6 / 00b

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 0 | 0 | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| 0 | ----- | ----- | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from July 26, 1949, to Sept. 12, 1950, that I last saw the deceased alive on 9 a.m. 9/12 1950 and that death occurred at 9:10 a.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Benjamin E. Hodge | M.D. | Dist. Training School, Laurel, Md. | 9-13-50 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Sept 14 | Dist Tr School | Laurel Alleo Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Sept 14 | Clara Haskins | Raymond Jones | Laurel Md |

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RECEIVED
OCT 6 1950
BUREAU V. S